DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC#2

PRINTED: 01/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

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F 000	INITIAL COMMENTS An annual Recertification survey and Complaint investigation #'s 27098, 27539, 28215, 28232 were completed at Life Care of Rhea County on January 9- 11, 2012. No deficiencies were cited related to complaint investigation #'s 27098, 27539, 28215, 28232, under 42 CFR PART 482.13, Regulations for Long Term Care.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	F164 What corrective action will be taken to correct this alleged deficient practice? a) On 1/20/2012 the director of nursing educated C.N.A #1 and #2 on privacy and dignity. b) All personnel were in-serviced on privacy for residents by the Staff Development Coordinator on 1/9/2012 and 1/26/2012. Identify residents that have the potential to be affected by the alleged deficient practice. a) All facility residents have the potential to be affected. b) Staff Development Coordinator completed a 100% observation on 1/26/2012 of privacy and dignity of all residents. No other residents were affected.	2/24/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kate Stafford | ED | 1-27-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to honor a resident's right to privacy for one resident (#1) of eighteen residents reviewed. The findings included: Resident #1 was admitted to the facility on February 24, 2011, with diagnoses including Parkinson's Disease, Dementia, Anemia, Transient Ischemic Attack, and Chronic Lymphocytic Leukemia. Medical Record review of the Minimum Data Set (MDS) dated November 8, 2011, revealed the resident was totally dependent for activities of daily living (ADL) and was incontinent of bowel. Observation on January 9, 2012, at 10:20 a.m., in the resident's room, revealed the resident lying on the left side of the body facing the outside window wall. Continued observation revealed the resident was receiving perineal care (washing of genital and rectal areas) for bowel incontinence by Certified Nursing Assistant (CNA) #1 and CNA #2. Continued observation revealed the privacy curtain was open and the resident was uncovered while perineal care was being performed. Continued observation revealed the resident's roommate was sitting in a wheelchair facing the resident and observing the perineal care. Interview with the Director of Nursing (DON) on January 10, 2012, at 1:52 p.m., in the hallway	F 164	What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a) All facility personnel were in-serviced on privacy and dignity of residents by the Staff Development Coordinator on 1/9/2012 and 1/26/2012. b) Unit manager and/or Assistant Director of Nursing will complete weekly observation on privacy and dignity of residents for four weeks and weekly for two months. c) The DON will audit the unit manager/ADON weekly observation for compliance starting on 1/27/2012 to 2/17/2012 and weekly for two months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? a) The Director of Nursing or Nursing Home Administrator will report the results of the privacy and dignity compliance audits to the performance improvement committee, which consist of the nursing home administrator, medical director, director of nursing, assistant director of nursing, staff development coordinator, pharmacy consultant,	

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F 164	Continued From page 2 outside the Administrator's Office, confirmed a resident's privacy curtain was to be closed when personal care is performed.	F 164	Cont. F164 human resource director, social service director, rehab services manager, dietary manager, admission/marketing coordinator, business office manager, wound care nurse, housekeeping/laundry director, activity coordinator, and health information manager, for three months. b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of manufacturer's specifications, facility policy, and interview, the facility failed to prevent medication errors less than five percent resulting in four errors within forty-six opportunities to equal an error rate of eight percent. Observations revealed errors occurred with one (Licensed Practical Nurse [LPN] #1) of five LPNs, one (New Side Hall) of two halls, one (Medication Cart #2) of three medication carts, one (6 a.m., to 2 p.m.,) of three shifts, and two (#10, #6) of eleven residents observed. The findings included: Medication Error #1 Observation on January 9, 2012, at 9:33 a.m., at the Medication Cart #2, revealed LPN #1 administered one Metformin 500 mg (milligram) tablet for Diabetes to Resident #10. Medical record review of the January 2012, Recapitulation orders for Resident #10 revealed an order for "...METFORMIN...500MG	F 332	F332 What corrective action will be taken to correct this alleged deficient practice? a) LPN #1 was educated on 1/9/2012 by the Staff Development nurse, on insulin administration, medications to be given with food, dilution of medications and medication not to be crushed. b) All licensed personnel were in-serviced on insulin administration, medications to be given with food, dilution of medications and medication not to be crushed on 1/9/2012 and 1/26/2012 by staff development coordinator.	2/24/2012

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F 332	Continued From page 3 TABLET...TAKE 1 TAB (tablet) BY MOUTH EVERY MORNING..." Review of the manufacturer's specifications for Metformin in the Geriatric Dosage Handbook Sixteenth Edition page 1103, under "...Administration..." revealed, "...administer with food (to decrease GI [gastrointestinal] upset)..." Review of the facility's policy, "Food/Water Recommendations for Certain Drugs", page 9-18 revealed Metformin was to be administered "With Food". Interview with LPN #1 on January 9, 2012, at 10:11 a.m., at the Medication Cart #2 outside resident rooms 23 and 24 in the New Side Front Hallway confirmed Resident #10 was not eating food at the time the Metformin was administered; the breakfast tray for Resident #10 was served on January 9, 2012, between 7:30 a.m., and 8:00 a.m.; and one medication error occurred when the Metformin tablet was not administered with food and approximately one hour and thirty minutes after breakfast was served. Interview with the Director of Nutritional Services on January 10, 2012, at 10:20 a.m., in the MDS (Minimum Data Set) office confirmed breakfast trays were served to the residents beginning at 7:30 a.m., and lunch trays were served to the residents beginning at 11:30 a.m., on January 9, 2012; and no other meal trays were served between breakfast and lunch. Medication Error #2 Observation on January 9, 2012, at 9:44 a.m., at	F 332	Identify residents that have the potential to be affected by the alleged deficient practice. a) All residents that receive insulin, medications to be given with food, medications to be diluted or medications that are not to be crushed could be affected. b) 100% audit of all residents that receive insulin, medications to be given with food, medications to be diluted or medications that are not to be crushed could be affected was completed by Assistant Director of Nursing on 1/27/2012. No other residents were affected. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a) All licensed personnel were in-serviced on insulin administration, medications to be given with food, dilution of medications and medication not to be crushed on 1/9/2012 and 1/26/2012 by staff development coordinator. b) A list of "do not crush" medications, medications to be diluted in water or juice, insulin perimeters, and medications to be given with food was placed on each medication administration record binder. c) Medication pass procedure will be observed weekly for 4 weeks then monthly for two months by the Director of Nursing or Staff Development Coordinator or pharmacy representative for compliance.	

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F 332	Continued From page 4 the Medication Cart #2, revealed LPN #1 administered 3 units of Humulin R Injectable Insulin 100 units per ml (milliliter) for Diabetes subcutaneously (under the skin) to the upper quadrant of the right arm of Resident #6. Medical record review of the January 2012, Recapitulation orders for Resident #6 revealed an order for "...Humulin R 100UNIT/1ML (milliliter) VIAL..." per sliding scale insulin "...FOUR TIMES DAILY..." Review of the manufacturer's specification for Humulin R insulin revealed, "...The injection of Humulin R U-100 should be followed by a meal within approximately 30 minutes of administration..." Interview with LPN #1 on January 9, 2012, at 10:09 a.m., at Medication Cart #2 outside resident rooms 23 and 24 in the New Side Front Hallway confirmed the breakfast tray for Resident #6 was served on January 9, 2012, between 7:30 a.m., and 8:00 a.m., and one medication error occurred when the Humulin R was not administered "thirty minutes before a meal" and approximately one hour and forty minutes after breakfast was served. Interview with the Director of Nutritional Services on January 10, 2012, at 10:20 a.m., in the MDS office confirmed breakfast trays were served to the residents beginning at 7:30 a.m., and lunch trays were served to the residents beginning at 11:30 a.m., on January 9, 2012; and no other meal trays were served between breakfast and lunch.	F 332	d) The DON or Nursing Home Administrator will review the Medication pass procedure observations starting on 1/27/2012 to 2/17/2012 and weekly for two months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? c) The Director of Nursing or Nursing Home Administrator will report the results of medication pass procedure audits to the performance improvement committee, which consist of the nursing home administrator, medical director, director of nursing, assistant director of nursing, staff development coordinator, pharmacy consultant, human resource director, social service director, rehab services manager, dietary manager, admission/marketing coordinator, business office manager, wound care nurse, housekeeping/laundry director, activity coordinator, and health information manager, for three months. b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	

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F 332	Continued From page 5 Medication Error #3 Observation on January 9, 2012, at 9:44 a.m., at the Medication Cart #2, revealed LPN #1 administered 15 mls (20 meq [milliequivalents]) of Potassium Chloride Solution for potassium replacement by mouth to Resident #6. Medical record review of the January 2012, Recapitulation orders for Resident #6 revealed an order for "...KCL (Potassium Chloride) 20 meq po (by mouth) BID (twice daily)..." Review of the pharmacy prescription label for Potassium Chloride Solution dispensed on December 22, 2011, to Resident #6 revealed administration instructions to "...Take with plenty of water. Dissolve in 4-8oz (ounces) water/juice. Take with food/meal..." Review of the manufacturer's label for Potassium Chloride Solution revealed, "...MUST BE DILUTED..." Review of the manufacturer's specification for Potassium Chloride in the Geriatric Dosage Handbook Sixteenth Edition pages 1437 and 1438, under "...Administration..." revealed, "...Oral dosage forms should be taken with meals..." Interview with LPN #1 on January 9, 2012, at 10:09 a.m., at Medication Cart #2 outside resident rooms 23 and 24 in the New Side Front Hallway confirmed Resident #6 was not eating at the time the Potassium Chloride Solution was administered and the breakfast tray for Resident #6 was served on January 9, 2012, between 7:30 a.m., and 8:00 a.m. Further interview with LPN #1	F 332		

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F 332	Continued From page 6 confirmed one medication error occurred when the Potassium Chloride was not diluted before administration; was administered without food and approximately one hour and forty minutes after breakfast was served. Interview with the Director of Nutritional Services on January 10, 2012, at 10:20 a.m., in the MDS office confirmed breakfast trays were served to the residents beginning at 7:30 a.m., and lunch trays were served to the residents beginning at 11:30 a.m., on January 9, 2012; and no other meal trays were served between breakfast and lunch. Medication Error #4 Observation on January 9, 2012, at 9:44 a.m., at Medication Cart #2, revealed LPN #1 crushed one Suboxone (combination medication of 8 mg Buprenorphine and 2 mg Naloxone) sublingual (under the tongue) film for pain and handed the dose to Resident #6. Resident #6 swallowed the crushed film without placing it under the tongue. Medical record review of the January 2012, Recapitulation orders for Resident #6 revealed an order for "...SUBOXONE SUBLINGUAL 8MG/2MG TABLET...TAKE 1 TAB BY MOUTH THREE TIMES DAILY..." Review of the manufacturer's specification for "...Method of Administration..." of Suboxone sublingual revealed, "...The sublingual film must be kept under the tongue until the film is completely dissolved. SUBOXONE sublingual film should NOT be chewed, swallowed, or moved after placement..."-	F 332		

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F 332	Continued From page 7 Interview with LPN #1 on January 9, 2012, at 10:09 a.m., at the Medication Cart #2 outside resident rooms 23 and 24 in the New Side Front Hallway confirmed a medication error occurred when the sublingual Suboxone film was crushed and administered by the incorrect route of swallowing.	F 332	F428 What corrective action will be taken to correct this alleged deficient practice? a) Resident #11 pharmacy recommendation was addressed immediately with the attending physician on 1/12/2012. Identify residents that have the potential to be affected by the alleged deficient practice. a) Residents in the facility that receive pharmacy services from the facility pharmacy have the potential to be affected. b) All other pharmacy recommendations for the month of December were reviewed by the director of nursing and found 100% compliance. No other residents were affected. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a) All monthly pharmacy recommendations will be taken to physician's office by Health Information Manager for their review starting 1/27/2012. A copy of the signed recommendation will be given to the Director of Nursing to ensure timely response. b) Director of Nursing will audit monthly recommendations for timely physician review beginning 1/28/2012 and ongoing.	2/24/2012
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the physician responded timely to pharmacy recommendations for one resident (#11) of eighteen residents reviewed. The findings included: Resident #11 was admitted to the facility on November 30, 2011, with diagnoses including Dementia, Anxiety, and Psychosis. Medical record review of a Pharmacy	F 428		

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F 428	Continued From page 8 Consultation Report dated December 13, 2011, revealed "...Recommendation: Please consider increasing Namenda (medication for dementia) to 10 mg (milligrams)...to twice daily as maintenance dose." Continued medical record review revealed the Physician had not responded to the recommendation. Interview with the Director of Nursing on January 11, 2012, at 11:40 a.m., in the Social Services office, confirmed the facility delayed notifying the physician of the Pharmacy recommendation.	F 428	How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? a) The Director of Nursing or Nursing Home Administrator will report the results monthly pharmacy recommendation audits to the performance improvement committee, which consist of the nursing home administrator, medical director, director of nursing, assistant director of nursing, staff development coordinator, pharmacy consultant, human resource director, social service director, rehab services manager, dietary manager, admission/marketing coordinator, business office manager, wound care nurse, housekeeping/laundry director, activity coordinator, and health information manager, for three months. b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		

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F 431	Continued From page 9 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of Tennessee Pharmacy Laws 2011 Edition, and interview, the facility failed to assure the contents of emergency medications for residents were secured in one (Blue Intravenous [IV] Emergency Box) of nine emergency boxes observed. The findings included: Observation of the Blue IV Emergency Box on January 9, 2012, at 12:59 p.m., in the New Side Medication Room with Licensed Practical Nurse (LPN) #2 revealed the box was not locked. Further review of the list of contents of the Blue IV Emergency Box revealed 23 Intravenous Solutions, including Dextrose 5% (per cent) with Water 1000 ml (milliliter) bag and Normal Saline 0.9% 1000 ml bag, were available for emergency use for residents. Review of the facility policy, "Emergency Drug Box...Procedure..." revealed "...1. The head nurse or a designee checks the expiration date	F 431	F431 What corrective action will be taken to correct this alleged deficient practice? a) Emergency box was locked immediately. b) Licensed personnel were in-serviced by the staff development coordinator on 1/9/2012 and 1/26/2012 on proper procedure for locking emergency boxes. Identify residents that have the potential to be affected by the alleged deficient practice. a) All emergency boxes were checked on 1/9/2012 to ensure they were locked properly. No other boxes were found unsecured. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a) Licensed personnel were in-serviced by the staff development coordinator on 1/9/2012 and 1/26/2012 on proper procedure for locking emergency boxes. b) Licensed personnel will check all emergency boxes on a daily basis starting 1/11/2012. c) The Assistant Director of Nursing or Director of Nursing will audit emergency lock boxes for proper locking starting 1/20/2012 to 2/17/2012 weekly and monthly for 2 months.	2/24/2012

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F 431	Continued From page 10 and seal on the box on each shift..." Review of the Tennessee Pharmacy Laws 2011 Edition Rule 1140-4-.09 Emergency and Home Care Kits page 210 documented "...(3) The emergency kit shall be provided sealed or electronically secured by authorized personnel in accordance with established policies..." Interview with LPN #2 on January 9, 2012, at 1:20 p.m., in the New Side Medication Room, confirmed the Blue Intravenous Emergency Box was unlocked and the contents of the emergency box were not secured per facility policy.	F 431	How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? a) The Director of Nursing or Nursing Home Administrator will report the results monthly pharmacy recommendation audits to the performance improvement committee, which consist of the nursing home administrator, medical director, director of nursing, assistant director of nursing, staff development coordinator, pharmacy consultant, human resource director, social service director, rehab services manager, dietary manager, admission/marketing coordinator, business office manager, wound care nurse, housekeeping/laundry director, activity coordinator, and health information manager, for three months. b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

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F 441	Continued From page 11 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility staff failed to maintain clean technique and wash the hands appropriately during a dressing change for two (#3, #6) of eighteen residents reviewed. The findings included: Observation on January 9, 2012, at 2:40 p.m., revealed Registered Nurse (RN) #1 providing wound care to resident #3. Observation revealed RN #1 removed a dressing from the resident's buttocks. Continued observation revealed RN #1 used a gauze pad to clean a wound on the right buttock with a scant amount of blood, and used the same gauze pad to clean an open wound on the left buttock. Continued observation revealed, without changing the gloves or washing the hands, RN #1 applied one large dressing to the wounds.	F 441	F441 What corrective action will be taken to correct this alleged deficient practice? a) RN #1 was educated by Director of Nursing and Staff Development Coordinator on infection control in relation to proper hand washing and usage of gloves on 1/9/2012 and 1/20/2012. b) All personnel were in-serviced on infection control in relation to proper hand washing and usage of gloves by staff development coordinator on 1/9/2012 and 1/26/2012. Identify residents that have the potential to be affected by the alleged deficient practice. a) All facility residents have the potential to be affected. b) Staff Development Coordinator completed a 100% observation on 1/26/2012 on infection control of all residents. No other residents were affected.	2/24/2012

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F 441	Continued From page 12 Review of the facility's policy Wound Care Procedure for Major Wounds revealed "...'Clean technique' is used...Put on clean gloves...Clean the wound according to the order. Clean from the center outward...Place soiled gauze used for cleaning in the bag...Remove gloves... " Interview on January 9, 2012, at 2:55 p.m., with RN #1, in the hallway, revealed RN #1 described the wounds on the right and left buttocks as Stage II pressure ulcers measuring approximately 1.2 cm (centimeters) by 1.4 cm. Continued interview revealed each wound was to be cleaned with a separate gauze pad, and confirmed the hands were to be washed after cleansing a wound prior to applying a clean dressing. Observation on January 9, 2012, at 2:00 p.m., revealed RN #1 providing wound care to resident #6. Observation revealed after completing wound care to resident #6, RN #1 removed the gloves and washed the hands. Continued observation revealed the following: RN #1 reapplied gloves and placed soiled linens into a plastic bag and picked up a bag with soiled dressings; placed the soiled linens into a laundry cart, and placed the bag with the soiled dressings into a biohazard storage box in the soiled utility room; removed the gloves and without washing the hands returned to resident #6's room and removed scissors from a drape on the resident's table, unlocked the dressing cart, and obtained a bleach wipe to clean the scissors. Review of the facility's policy Standard Precautions revealed "...The purpose is to reduce the risk of transmission of infection,	F 441	What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a) All personnel were in-serviced on infection control in relation to proper hand washing and usage of gloves by Staff Development Coordinator on 1/9/2012 and 1/26/2012. b) Director of Nursing will conduct visual audits starting 1/19/2012 to 2/16/2012 and then monthly for two months on proper infection control process during wound care with wound care nurse. c) Nursing Home Administrator will audit the infection control process weekly reviews for compliance for four weeks and monthly for two months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? a) The Director of Nursing or Nursing Home Administrator will report the results infection control audits to the performance improvement committee, which consist of the nursing home administrator, medical director, director of nursing, assistant director of nursing, staff development coordinator, pharmacy consultant, human resource director, social service director, rehab services manager, dietary manager, admission/marketing coordinator, business office manager, wound care	

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F 441	Continued From page 13 Standard precautions apply to all residents and in all situations...The required elements of standard precautions include: 1) adequate hand hygiene at all times...Follow hand hygiene recommendations immediately or as soon as feasible after removal of gloves..." Interview on January 9, 2012, at 2:25 p.m., with RN #1, in the hallway, confirmed the hands were not washed after placing the soiled linens into the laundry cart and the soiled dressing into the biohazard storage box, and removing the gloves, prior to reentering the resident's room and unlocking the dressing cart to clean the soiled scissors.	F 441	cont F441 nurse, housekeeping/laundry director, activity coordinator, and health information manager, for three months. b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved	